NOTE: Use these buttons to print or save the form. DO NOT use the browser tool bar. SAVE PRINT

Los Alamos NATIONAL LABORATORY EST.1943
The World's Greatest Science Protecting America

Insurance Enrollment

(*This form will supersede all previous enrollment forms*)
Return to Benefits Office, MS P280

Personal Information (*please print or type*)

Employee (*Last, First, Middle Initial*)	Z Number	Group	Mail stop	Birthdate	Social Security Number
Mailing Address (*Number, Street, City, State, Zip*)		Age	E-Mail		Home Phone: Work Phone:

Type of Action or Qualifying Event

Select one of the appropriate boxes below. Date of Qualifying Event: _____

❑ New Hire	❑ Address Change	❑ Health Statement	❑ Domestic Partner Enrollment	❑ Leave Without Pay
❑ HIPPA Enrollment	❑ Dependent Loss of Eligibility	❑ Loss of Other Coverage	❑ Leave With Pay	❑ Open Enrollment
❑ New Child	❑ Return From Leave	❑ Short Term Disability	❑ Entrepreneurial Leave 1	
❑ Marriage	❑ BELI Code Change	❑ FMLA	❑ Entrepreneurial Leave 2	
❑ Manual Change	❑ Divorce	❑ Death of Dependent	❑ Entrepreneurial Leave 3	

Eligible Family Member Actions or Qualifying Event

Complete this section to: (1) enroll your eligible family members in the plans in which you are enrolled; (2) de-enroll your eligible family members form these plans; or (3) change personal data (e.g., correct a misspelled name or provide a child's Social Security Number). **Indicate an "E" for enroll, a "D" for de-enroll, or "C" for change in the action box and make a check mark in the appropriate insurance plan box. Circle the appropriate RELATIONSHIP category below.**

Action (E,D,C)	Name (Last, First, MI)	Sex	Relationship (Circle One)	Birthdate	SSN (Required)	Med	Den	Vis	Leg	Dis	Life	Dep Life	AD &D
			Employee	MO DY YR									
			Spouse (S) Domestic Partner (D)	MO DY YR									
			Natural/Adopted (C) Stepchild (P) Legal Ward (W) Disabled Grand Child (G) SSDP child/grandchd (k) Non tax dep child (T)	MO DY YR									
			Natural/Adopted (C) Stepchild (P) Legal Ward (W) Disabled Grand Child (G) SSDP child/grandchd (K) Non tax dep child (T)	MO DY YR									
			Natural/Adopted (C) Stepchild (P) Legal Ward (W) Disabled Grand Child (G) SSDP child/grandchd (K) Non tax dep child (T)	MO DY YR									

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Insurance Plans

Medical (01)

❑ Enroll ❑ Cancel ❑ Change ❑ No Change

❑ Emp ❑ Emp + Adult ❑ Emp + Child(ren) ❑ Emp + Family

Residing Within EPO Service Area:

❑ Select EPO ❑ Definity Health

❑ Options PPO NM ❑ Core (20)

Residing Outside EPO Service Area:

❑ Options PPO National ❑ Other: _____

❑ Options PPO Out of Area ❑ Core

Dental (15)

❑ Enroll ❑ Cancel ❑ Change ❑ No Change

❑ Emp ❑ Emp + Adult ❑ Emp + Child(ren) ❑ Emp + Family

Vision (47)

❑ Enroll ❑ Cancel ❑ Change ❑ No Change

❑ Emp ❑ Emp + Adult ❑ Emp + Child(ren) ❑ Emp + Family

Opt Out of University-Sponsored Coverage

I wish to decline coverage under the following university-sponsored plans:

❑ Medical ❑ Dental ❑ Vision

I am declining this coverage because (*check one*)

❑ I am currently covered as a spouse, dependent, or annuitant under a University-sponsored plan(s) Covered participant's Z No. or Name: _____

❑ I am currently covered under a non-University group plan(s). I understand that if I opt out of University-sponsored coverage that the UC plans will not cover me or my family.

Cancellation of a Previous Opt-Out Request

I wish to cancel a previous opt-out request for the following University-sponsored plans:

❑ Medical ❑ Dental ❑ Vision

I am canceling the previous opt-out because (*check one*)

❑ an involuntary loss of other group coverage. (***Please attach a letter from the employer certifying that you and your family member(s) were enrolled in the plan(s) and coverage end date.***)

❑ an Open Enrollment/Appointment Change ❑ a change in religious beliefs (*check as appropriate*)

Legal (54)

❑ Enroll ❑ Cancel ❑ Change ❑ No Change

❑ Emp ❑ Emp + Adult ❑ Emp + Child(ren) ❑ Emp + Family

Employee-Paid (Supplemental) Disability (04)

❑ Enroll ❑ Cancel

❑ Decrease Waiting Period (*subject to statement of health*) ❑ Increase Waiting Period

❑ 7 days ❑ 30 days ❑ 90 days ❑ 180 days

Employee-Paid (Supplemental) Life (02)

❑ Enroll ❑ Cancel ❑ Change ❑ No Change

❑ 1 Time Annual Salary ❑ 2 Time Annual Salary ❑ 3 Time Annual Salary ❑ 4 Time Annual Salary ❑ $20,000

Employee-Paid Dependent Life (59)

❑ Enroll ❑ Cancel ❑ Change ❑ No Change

❑ Basic Plan (*includes spouse/same sex* domestic *partner and/or children $5,000 each*)

❑ Expanded Plan (*Select type of coverage*):

❑ Spouse/Same Sex Domestic Partner Only ❑ Child(ren) Only

❑ Spouse/Same Sex Domestic Partner and Child(ren)

Accidental Death and Dismemberment (03)

❑ Enroll ❑ Cancel ❑ Change ❑ No Change

❑ Family ❑ Modified Family [Emp + Child(ren)]

Coverage Amount (*Check One*)

❑ $10,000 ❑ $50,000 ❑ $90,000 ❑ $150,000 ❑ $300,000

❑ $20,000 ❑ $60,000 ❑ $100,000 ❑ $175,000 ❑ $400,000

❑ $30,000 ❑ $70,000 ❑ $125,000 ❑ $200,000 ❑ $500,000

❑ $40,000 ❑ $80,000

Note: *Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fine and criminal penalties.*

Employee Name	Employee Signature	Z Number	Date	Benefits Specialist	Date

Dependency Affidavit

if you have circled stepchild, grandchild, ward, or other child for any dependent listed above, your signature below indicates agreement to the terms of this dependency affidavit. I certify that the stepchild(ren)/grandchild(ren) listed are unmarried, under the age of 25 if enrolled in Dental or Vision, and under 23 if enrolled in any other plan, permanently living with me, dependent on me, my spouse, or domestic partner for a least 50% support, and are declared as my dependents on my income tax returns, and that for those under age 18, I am legally empowered to authorize medical treatment. For as long as eligible plan members are enrolled, I agree to provide the University of California with copies of my annual income tax returns. I also understand that I will be liable for all costs incurred as a result of invalid enrollments. I certify that I have read, understand, and agree to the terms and conditions of these actions. All of the above information is true to the best of my knowledge. I understand that the University reserves the right to cancel coverage for ineligible dependents in cases where enrollment is contrary to the group insurance regulation

_____

Employee Signature (*Signature required if Dependency Affidavit is applicable*)

PRIVACY NOTIFICATION

STATE

The State of California Information Practices Act of 1977 (effective July 1, 1978) requires the University to provide the following information to individuals who are asked to supply information about themselves.

The principal purpose for requesting the information on this form is for payment of earnings and for miscellaneous payroll and personnel matters such as, but not limited to, withholding taxes, benefits administration, and changes in title and pay status. University policy and state and federal statues authorize the maintenance of this information.

Furnishing all information requested on this form is mandatory. Failure to provide such information will delay or may even prevent completion of the action for which the form is being filled out. Information furnished on this form may be used by various University departments for payroll and personnel administration and will be transmitted to the federal and state governments as required by law.

Individuals have the right to review their own records in accordance with University personnel policy and collective bargaining agreements. Information on applicable policies and agreements can be obtained from campus or Office of the President Staff and Academic Personnel Offices.

The officials responsible for maintaining the information contained on this form are Office of the President and campus Academic and Staff Personnel Managers or campus Accounting Officers.

FEDERAL

Pursuant to the Federal Privacy Act of 1974, you are hereby notified that disclosure of your Social Security number is mandatory. Disclosure of the Social Security number is required pursuant to sections 6011 and 6051 of Subtitle F of the Internal Revenue Code and with Regulation 4, Section 404.1256, Code of Federal Regulations under Section 218, Title II of the Social Security Act, as amended. The Social Security number is used to verify your identity. The principal uses of the number shall be to report (1) state and federal income taxes withheld, (2) Social Security contributions, (3) state unemployment and Workers' Compensation earnings, (4) earnings and contributions to participating retirement systems, and (5) as an identifier for your insurance carrier to verify your eligibility and to maintain claim records for you and your eligible family members.

INSURANCE ENROLLMENT, CHANGE, CANCELLATION, OR OPT OUT

Use this form to enroll, change, cancel or opt out of University of California (UC) insurance plans for yourself and/or your eligible family members. For complete information on eligibility, effective dates, and allowable actions, see *Your Group Insurance Plans,* available in the Benefits Office. **Please note that you must be a member of a UC-sponsored defined benefit retirement plan to enroll in the dental, vision, and/or legal plans.**

If you are enrolling eligible family members in any of these plans, or cancelling eligible family member coverage, you must also complete the section on Eligible Family Member Actions. List **only** the eligible family member(s) you wish to enroll or de-enroll, or for whom you are changing personal data. Current enrollments will remain in effect until you notify the University of a change.

If you are changing plans, your enrolled family members will change plans automatically. Please note that you may only enroll your eligible family members in the plans in which you are enrolled.

TERMS AND CONDITIONS

Your signature on this form indicates agreement to the following terms and conditions:

If I enroll family members, the University may periodically request proof of eligibility (marriage and/or birth certificates, adoption and/or tax records, etc.). I agree to provide such documentation upon request and I understand that if I do not, the family member(s) will be de-enrolled retroactively and I will be liable for all costs incurred during the invalid enrollment period.

I certify that

(1) the child(ren) listed in the Eligible Family Member Actions section of this form are unmarried and under the age of 25 if enrolled in Dental or Vision, and under the age of 23 if enrolled in any other plan (unless disabled and eligible to continue coverage past age 22), or under age 18 if I have legal guardianship; and

(2) any stepchildren or grandchildren listed are unmarried, living with me, dependent on me or my spouse for at least 50% support, and declared as my or my spouse's dependent(s) on our income tax returns; and

(3) legal wards or "other" children listed are unmarried, living with me, dependent on me for at least 50% support, and declared as my dependent(s) on my income tax returns.

I authorize deductions from my earnings to cover premiums, if any, for the plans I have selected for myself and my eligible family members. This authorization will remain in effect until, or unless, I submit another form changing, cancelling, or opting out of coverage. I understand that these deductions will continue for two months while I am on paid leave from University employment unless I take positive action to stop them.